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Health -E- News

SECTION NEWS

Excellent Inaugural CLE on Fraud and Abuse

The January 22, 2004 morning CLE was presented by Jennifer Stone (Miller Law Firm). Jennifer's materials provided an excellent over-view of the topic of fraud and abuse, with citations to statutes and regulations. The attendance was poor – even for an early morning CLE—because of some miscommunication regarding notice in the Bar Bulletin. That problem has been corrected and future CLEs will be printed in the Calendar of events. You may contact the State Bar CLE office to obtain a copy of the taped proceedings and the materials.

February's HLS CLE will address 2004 NM Legislative Update on Health Care

It will start **at noon** on **February 26th** at the State Bar Office. If you want to network over a brown bag lunch, bring your own bag and meet at 11:30 AM. The program is free unless you want one hour CLE credit and the handouts. For Section members the CLE credit and materials will cost \$20. For non-section members the cost will be \$25. The Section hopes to have a list of House and Senate Bills that were passed. At this point the Governor will probably not have acted on any of the bills, but those who attend will know what he can sign and what he can veto. Lunch is not being provided at this CLE. Bring your own lunch and join us at 11:30 to "talk health law."

Membership News.

To the extent that the Health-E-News has room, it will publish announcements regarding personnel changes, moves, or kudos for lawyers in New Mexico's health care legal community. Send the proposed announcement to JAB@NMCounsel.com.

NEW HEALTH LAW DEVELOPMENTS

New "New Mexico Privacy Protection Act" May Cause Confusion

All lawyers have a new statute to deal with - The New Mexico Privacy Protection Act, which became effective on January 1, 2004. It is found at NMSA 57-12B-1 thru 3 (2003 Cum. Supp.). It may cause health care providers a headache or two.

It is broadly worded and defines "business" to mean "a commercial enterprise that sells or leases or intends to sell or lease products goods or *services* to consumers." (57-12B-2(A)). It doesn't define services and therefore doesn't expressly exempt health care services. "Consumer" is defined as a natural person who purchases, leases or otherwise contracts for products goods or *services* within

NM that are "...primarily used for personal, family, or household purposes." (57-12B-2(B)). Thus, healthcare providers (including nonprofits) fall within the definition of a "business" and patients fall within the definition of "consumer."

Section 57-12B-3(A) prohibits a business from requiring a consumer's social security number as a condition for a consumer to lease or purchase, products, goods or *services* from the business. However, subsection A refers to the exception in B, and subsection B reads as follows:

B. Nothing in this section prohibits a business from requiring or requesting a consumer's social security number if the number will be used in a manner consistent with state or federal law or as part of an application for credit or in connection with annuity or insurance transactions.

Subsection C permits the social security number to be collected with the consumer's consent, and subsection D requires the business to safeguard the number by limiting access to employees whose job duties require them to have access to the social security number, and to hold employees responsible if social security numbers are released to unauthorized persons. If the statute applies to an employer, it may be a good idea to redraft some job descriptions and issue a policy statement regarding the statute and the consequences if it is violated.

This statute appears in the Chapter of laws titled Trade Practices and Regulations, and not in the health care section of the statutes. It appears to be intended to protect consumers in commercial transactions, and the exception in 57-12B-3(B) should cover collection of the social security number by health care providers. That doesn't mean that patients won't be misled by media coverage or "street lawyers" into believing that health care providers cannot ask for a social security numbers. [Contributed by John A. Bannerman of Bannerman & Williams, P.A.].

GAO Report Finds Assistants-At-Surgery Services Should Be Paid Under Inpatient PPS

A new report by the General Accounting Office (GAO) concluded that all Medicare payments for assistants-at-surgery services should be paid under the hospital inpatient prospective payment system (PPS). The report "Medicare: Payment Changes are Needed for Assistants-at-Surgery" (GAO-04-97) is the result of a congressional request for a report on the potential impact of allowing Certified Registered Nurse First Assistants that perform assistants-at-surgery services to be paid under the physician fee schedule. GAO determined that Medicare pays assistants-at-surgery under different payment schedules and may be overpaying, that the differences in payments do not provide an incentive to use assistants-at-surgery only when it is medically necessary, and that the differences in payment are not based on education or experience. Therefore, Medicare should consolidate all assistants-at-surgery services payments under the hospital inpatient PPS, recommended GAO.

To read the GAO report, go to http://www.healthlawyers.org/docs/ask2004/GAO_04_97.pdf

Lawmakers Expand Probe Of Medicaid Fraud, Ask Retail Pharmacies For Documents

House Energy and Commerce Committee Chairman W.J. "Billy" Tauzin (R-LA) and Oversight and Investigations Subcommittee Chairman James Greenwood (R-PA) sent letters January 14 to five of the nation's largest pharmacy retail chains in connection with the ongoing investigation into Medicaid waste, fraud, and abuse. The letters ask the five chains to supply documents related to pharmaceutical reimbursements and rebates under Medicaid. The five letters were sent to CVS President and CEO Tom Ryan, Eckerd Chairman and CEO Wayne Harris, Rite Aid President and CEO Mary Sammons, Walgreen Chairman and CEO David Bernauer, and Wal-Mart Stores President and CEO H. Lee Scott, Jr.

[Much of the controversy in the area of prescription drugs has to do with how drug rebates are manipulated and reimbursement at rates based upon Average Wholesale Price ("AWP"). AWP is viewed by regulators as an artificially inflated price that has no rational relationship to actual wholesale cost. While

this inquiry is looking at national chains, many pharmacies belong to regional or national networks or buying groups, like LeaderNet, United Drugs, and even the locally owned and controlled Regent Drugs of New Mexico].

To read the letters, go to http://energycommerce.house.gov/108/News/01142004_1173.htm

CBO Finds Tort Liability Reform May Not Have Significant Economic Effect

Large savings for medical malpractice premiums because of tort liability restrictions would only have a small direct impact on healthcare spending because malpractice costs account for less than 2% of healthcare spending, a new policy brief from the Congressional Budget Office (CBO) found. The report, "Limiting Tort Liability for Medical Malpractice," examined the possible effects of congressional proposals to restrict malpractice awards. The CBO found that malpractice premiums rose 15% on average from 2000 through 2002, with a 22% increase for obstetricians/gynecologist and a 33% increase for internists and general surgeons.

To read the CBO's policy brief, go to http://www.healthlawyers.org/hlh/docs/CBO_brief_040119.pdf

Biotech & Patent Strategies.

For some interesting insight into Biotech strategies, go to <http://practice.findlaw.com/feature-0104.html>

Need Some Guidance on Benefits - Health and Otherwise?

Here is a searchable website with information, links to other sites, Q & As, you name it!
www.benefitslink.com

Medical Group not a Health Care Provider for Certain Purposes.

A medical group consisting of a partnership of physicians is not a "health care provider" as that term is defined under the Medical Injury Compensation Reform Act, because the group is not itself licensed to practice medicine. The group is subject to the Act's \$250,000 cap on non-economic damages as an employer held vicariously liable for the negligent acts of its licensed physician employees.

LATHROP v. HEALTHCARE PARTNERS MED. GROUP, No. A098487
(California Appellate Districts, January 21, 2004)

To read the full text of this opinion, go to:

<http://login.findlaw.com/scripts/callaw?dest=ca/caapp4th/slip/2003/a098487.html>

CMS Issues Final Rule Establishing The Standard Unique Identifier For Providers

Healthcare providers will be required to use the National Provider Identifier (NPI) as the standard unique identifier in filing and processing healthcare claims and other transactions, according to a final rule published in the January 23 Federal Register (69 Fed. Reg. 3434). The standard unique health identifier is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), said the Centers for Medicare and Medicaid Services (CMS) in announcing the new rule. The NPI will replace all "legacy" identifiers that are currently in use. The final rule is effective May 23, 2005. According to CMS, providers may begin applying for NPIs on that date. To read the final rule, go to

http://www.healthlawyers.org/hlh/docs/69fr_3434_040126
(Note: link will open an Adobe Acrobat PDF file)

Editor's Comments: In the Beginning before there was HIPAA; the Clinton Administration made the decision to move the country toward a unified health care system in which health information, including billing information, will be transmitted electronically. To accomplish this, providers needed a unique provider number, which is called the National Provider Identifier or NPI number, much like each pharmacy has a unique NAPB number for the purpose of billing and compliance with DEA requirements). Thus, HIPAA set in motion a number of procedures and deadlines. This Final Rule partially completes the work that needs to be done to move the country toward a universal means of transmitting healthcare information.

Another important aspect of this plan is a single Unique Health Identifier (UHI) for each patient using the system. The number has to be long enough to provide a significant amount of information about the patient. In 1998 Congress put this aspect of HIPAA on hold. The debate still rages about how long this number should be, the type of information it should contain, and whether or not security measures can be devised to make its use worthwhile. In part, because the UHI will itself contain personal health information (PHI—are you keeping up with this?), HIPAA required CMS to promulgate Privacy Regulations. Those Regulations, which became effective last April, took us a step closer to the day when Congress must deal with the UHI. When the provider and the patient numbers are in place (along with the new code set for billing purposes which is now being implemented), all of the major impediments for universal billing for health care will be removed.

The argument over the length of the UHI focuses on the amount of information that can be conveyed within the number. An example would be the VIN number on your car. It tells the body shop what color to use, where it was manufactured, etc. Another example is the national tracking number for cattle, which is intended to help track down cows with mad cows disease. The 9 digits in the social security number are not inadequate this purpose, and the social security number has it's own security proponents. (See the article on the new NM statute at the beginning of this newsletter). Depending on the length of the new number, a patient's date of birth, sex, and general health status will be known as soon as the number is scanned. Obviously, the use of such a number raises significant privacy issues. The HIPAA Privacy regulations, are only a partial step toward what may become a universal ID card. For more information about the UHI visit these websites:

<http://www.hhs.gov/asl/testify/t980917a.html>

<http://www.hipaonet.com/upin4.htm>

<http://www.preventhacking.com/hipaa-security-regulations.htm>

CMS Announces 10.6% Average Increase In Payment Rates For Medicare Managed Care Plans

CMS announced January 16 that payment rates to health plans participating in the Medicare Advantage program will increase by an average of 10.6%. The recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated the increased payments to Medicare Advantage, which was formerly known as Medicare+Choice. The additional funding must be used to reduce beneficiary premiums or co-payments, enhance benefits, stabilize provider networks, or be reserved to offset future premium increases or reductions in benefits. The new payment rates will be effective March 1 through December 2004. Payments for February will be adjusted to reflect the increases in the revised rates for January and February, the agency said.

To read CMS' press release on the new payment rates, go to
<http://cms.hhs.gov/media/press/release.asp?Counter=944>

To view the new rates, go to
<http://www.cms.hhs.gov/healthplans/rates/>

This Email Newsletter is a publication for the members of the Health Law Section of the New Mexico State Bar Association. Its contents may be time dated, and references to Internet sites may change. The Content of this Newsletter does not reflect the opinions of the Members of the Board of Directors of the Health Law Section of the State Bar. This Newsletter is informational only, does not constitute legal advice. Members of the Health Law Section may submit topics for the newsletter by emailing them, or the internet site at which they can be located, to JAB@NMCounsel.com